

## Referral for Temporary Assistance through the South Dakota Indigent Medication Program

*The Division will use this information to pay for any laboratory work, purchase medications and/or apply to any online pharmaceutical program to acquire psychotropic medications.*

**Please print clearly.**

Date: \_\_\_\_\_ Person assisting with this form/Title: \_\_\_\_\_

Client Name: \_\_\_\_\_

First \_\_\_\_\_ MI \_\_\_\_\_ Last \_\_\_\_\_  
Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_ Soc. Sec. #: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Sex: Male \_\_\_\_\_ Female \_\_\_\_\_

Married \_\_\_\_\_ Single \_\_\_\_\_ Widowed \_\_\_\_\_ Separated \_\_\_\_\_ # People in household \_\_\_\_\_

**Last hospitalization for mental illness:**

Date: \_\_\_\_\_ Where: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

**List where you receive your income (including Spouse's income) as well as the \$ amounts:**

Are you currently employed? Yes \_\_\_\_\_ Hrs/week \_\_\_\_\_ No \_\_\_\_\_ Volunteer work \_\_\_\_\_

Yearly Household Income: yourself \$ \_\_\_\_\_ spouse \$ \_\_\_\_\_

Do you currently have any Insurance plan that pays for prescription drugs: yes \_\_\_\_\_ no \_\_\_\_\_

Supplemental Security Income (check on the first of the month): \$ \_\_\_\_\_

Soc. Sec. Disability Insurance (check on the 3<sup>rd</sup> of the month): \$ \_\_\_\_\_

Do you have Medicare Benefits? Part A \_\_\_\_\_ Part B \_\_\_\_\_

Have you applied for a Medicare Part D insurance for your prescriptions? Yes \_\_\_\_\_ No \_\_\_\_\_

***Pharmacy:***

Pharmacy you plan to use \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax (if known): \_\_\_\_\_

***Health care center where lab is to be done:***

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

CMHC: \_\_\_\_\_

On Waiting List: yes \_\_\_\_\_ no \_\_\_\_\_

Drug	Milligrams	Frequency	Can generic be used? Y/N	Why is this medication prescribed?
Lab test needed	How often does this need done?			Why is this test to be done?

I declare and affirm under the penalties of perjury that this information has been examined by me, and to the best of my knowledge and belief, is in all things true and correct.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Return forms (release of information, referral, drug list, and denial notice) to:

Division of Mental Health  
Hillsview Properties Plaza, East Highway 34  
c/o 500 East Capitol  
Pierre, South Dakota 57501-5070

Phone: (605)773-5991 1-800-265-9684

Fax: (605)773-7076

**DIVISION OF MENTAL HEALTH AUTHORIZATION TO EXCHANGE  
INFORMATION**

**I hereby authorize the Division of Mental Health to release and/or exchange information both orally and in writing, with respect to diagnosis and course of treatment of my mental illness with any Community Mental Health Center, pharmacy, medical provider, provider of laboratory services, and/or pharmaceutical programs.**

**Consumer/Guardian Signature \_\_\_\_\_ DATE \_\_\_\_\_**

**I acknowledge that the South Dakota Division of Mental Health will pay for my psychotropic medications and/or lab costs on a time-limited basis, as determined by the Division of Mental Health.**

**I understand the above criteria and the terms/conditions of my participation in the program offered through the Division of Mental Health.**

**I agree to the following as terms of this medication/laboratory funding agreement:**

- **I will take all psychotropic medications as prescribed.**
- **I will be responsible to cover the cost of replacing lost or damaged medications.**
- **I will not sell, give away or otherwise distribute medications intended for personal use.**
- **I will keep all scheduled psychiatric appointments and comply with treatment.**
- **I will develop a plan for long term needs as state funding is limited.**
- **I understand that funding may end with no greater than a 30 day notice.**
- **I will continue to exhaust all other funding resources.**
- **I authorize the exchange/release of relevant and necessary medical/psychiatric information to the Division of Mental Health.**
- **I agree to inform the South Dakota Division of Mental Health if Medicaid or private health insurance is obtained.**
- **I understand that failure to comply with the above-based requirements will result in my termination from the program and/or repayment.**
- **I understand that if this application is not complete or correct, this application will be destroyed.**
- **I understand that this application will be effective one year from the date originally signed.**
- **I understand that I may revoke my consent at any time and that revocation is effective upon receipt, except to the extent previously relied upon.**

**Consumer/Guardian Signature \_\_\_\_\_ DATE \_\_\_\_\_**